General

Guideline Title

British Association of Dermatologists' guidelines for the management of squamous cell carcinoma *in situ* (Bowen's disease) 2014.

Bibliographic Source(s)

Morton CA, Birnie AJ, Eedy DJ. British Association of Dermatologists' guidelines for the management of squamous cell carcinoma in situ (Bowen's disease) 2014. Br J Dermatol. 2014 Feb;170(2):245-60. [174 references] PubMed

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Cox NH, Eedy DJ, Morton CA, Therapy Guidelines and Audit Subcommittee, British Association of Dermatologists. Guidelines for management of Bowen's disease: 2006 update. Br J Dermatol. 2007 Jan;156(1):11-21. [70 references]

Recommendations

Major Recommendations

Definitions for the levels of evidence (1++, 1+, 1-, 2++, 2+, 2-, 3, 4) and strength of recommendations (A-D) are presented at the end of the "Major Recommendations" field.

Table 1: Summary of the Main Treatment Options for Squamous Cell Carcinoma (SCC) *In Situ*

The suggested scoring of the treatments listed takes into account the evidence for benefit, ease of application or time required for the procedure, wound healing, cosmetic result and current availability/costs of the method or facilities required. Evidence for interventions based on single studies or anecdotal cases is not included.

Lesion Characteristics (small, <2 cm)	Topical 5-FU	Topical Imiqumod[b]	Cryotherapy	Curettage	Excision	PDT	Radiotherapy	Laser
Small, single/few, good healing[a]	3	3	2	1	3	3	5	4
Large, single, good healing[a]	3	3	3	4	5	2	4	–
Multiple, good healing[a]	2	3	2	3	5	3	4	4
Small, single/few, poor healing	2	2	3	2	2	2	5	–

Lesion Characteristics	Topical 5-FU	Topical Imiquimod[b]	Cryotherapy	Curettage	Excision	PDT	Radiotherapy	Laser
Large, single, poor healing site[a] (small, <2 cm)	5	2	5	4	5	1	6	–
Facial	3	3	4	2	4	3	4	–
Digital	3	3	4	5	2	3	3	3
Nail bed	–	4	–	–	2[c]	3	4	4
Penile	3	3	4	5	4[c]	3	3	3
Lesions in immunocompromised patients	5	4	3	3	4	3	–	–

FU, fluorouracil; PDT, photodynamic therapy

1, probably treatment of choice; 2, generally good choice; 3, generally fair choice; 4, reasonable but not usually required; 5, generally poor choice; 6, probably should not be used; –, insufficient evidence available.

[a]Refers to the clinician's perceived potential for good or poor healing at the affected site.

[b]Does not have a product license for SCC *in situ*.

[c]Consider micrographic surgery for tissue sparing or if poorly defined or recurrent.

Treatments

No Treatment (Strength of Recommendation D [Good Practice Point]; Level of Evidence 4)

In some patients with slowly progressive thin lesions, especially on the lower leg of elderly patients where healing is poor, there is an argument for observation rather than intervention. In these cases use of an emollient (especially one containing urea) can reduce the scaling and make it less obvious (see Appendix 1 in the original guideline document).

5-Fluorouracil (5-FU) (Strength of Recommendation B; Level of Evidence 1+)

Topically applied 5-FU is a well-recognized treatment option for SCC *in situ* and is commercially available in the U.K. as a 5% cream. Many of the original studies were performed using different concentrations and various regimens. The typical regimen in current clinical use is once- or twice-daily application for 3 to 4 weeks, repeated if required.

Imiquimod (Strength of Recommendation B; Level of Evidence 1+)

Imiquimod stimulates both the innate and acquired immune systems, resulting in antitumour and antiviral activity. It is available as a topical 5% cream and has been used to treat SCC *in situ*, although its licence in the U.K. is only for superficial basal cell carcinoma (BCC), actinic keratoses and genital warts. It is generally well tolerated, but it does cause significant erythema and crusting, so appropriate counselling needs to be given prior to treatment.

Cryotherapy (Strength of Recommendation B; Level of Evidence 1+)

Cryotherapy is a simple, inexpensive and quick method of treating SCC *in situ*, with the advantage of accessibility in the outpatient setting. Clearance rates for cryotherapy vary widely, probably reflecting differences in the techniques and regimens used, with failure rates in the order of 5% to 10% in the larger series, provided that adequate cryotherapy is used (e.g., liquid nitrogen cryotherapy, using a single freeze–thaw cycle [FTC] of 30 s, two FTCs of 20 s with a thaw period, or up to three single treatments of 20 s at intervals of several weeks). However, such doses do cause discomfort and may cause ulceration, especially on the lower leg.

Curettage with Cautery/Electrocautery (Strength of Recommendation C; Level of Evidence 2+)

Curettage and cautery has been advocated as one of the simplest, least expensive, safest and most effective methods of dealing with SCC *in situ*, but its success is determined by the skill of the operator.

Excision (Strength of Recommendation C; Level of Evidence 2+)

This is a simple, rapid and effective treatment for SCC *in situ* of limited size and located in suitable areas. It allows for verification of the diagnosis and confirmation of the intraepithelial nature of the lesion. Cosmetic outcome, body site, healing properties and vascularity of the area need to be considered.

While it is logical that excision should be an effective treatment, the evidence base is limited. Additionally, lower-leg excision wounds may be associated with considerable morbidity.

Mohs Micrographic Surgery (Strength of Recommendation D; Level of Evidence 3)

Mohs micrographic surgery may be indicated for digital SCC *in situ* (around the nail in particular) and for some cases of genital (especially penile) SCC *in situ* for its tissue-sparing benefits. There may also be a role for Mohs in recurrent or incompletely excised lesions.

Photodynamic Therapy (PDT) (Strength of Recommendation A; Level of Evidence 1++)

PDT for SCC *in situ* involves topical application of the photosensitizer prodrug aminolaevulinic acid (ALA) or its more lipophilic methyl ester methyl aminolaevulinate (MAL). MAL is applied under occlusion for 3 h followed by illumination using red light, with narrowband light-emitting diode (LED) sources in routine use. Treatment is repeated 7 days later and again after 3 months, if required. Several protocols have been described for ALA-PDT in SCC *in situ* as outlined in the original guideline document, with nonformulary ALA often used. Fluorescence diagnosis, the identification of lesions using the fluorescence detectable after MAL/ALA occlusion, achieved 100% sensitivity (higher than clinical evaluation alone) and a specificity of 85.7% in a recent study in SCC *in situ*.

Radiotherapy (Strength of Recommendation D; Level of Evidence 2+)

Various radiotherapy techniques have been used to treat SCC *in situ*, with no standardized protocol, and a recent literature review concluded that both high- and low-dose regimens appear equally efficacious. Disadvantages include cost, patient inconvenience and poor healing, particularly on the leg. Advantages are that it can be used to treat areas where surgical modalities are difficult, and it can be used even on the scalp.

Laser (Strength of Recommendation D; Level of Evidence 3)

Experience of laser for SCC *in situ* is restricted largely to case reports and small series; it is considered for potentially more challenging treatment sites including the digits and genitalia.

Table 2: Summary of Treatment Choice

Treatment	Strength of Recommendation
Cryotherapy: simple, inexpensive and quick method of treating SCC *in situ*. Lesions heal better than with radiotherapy, but not as well as those treated with curettage or PDT	B
Success (of curettage with cautery): simple, inexpensive, safe and effective method of treating SCC *in situ*. Preferable to cryotherapy in terms of pain, healing and recurrence rate	C
Excision: simple, rapid and effective treatment for SCC *in situ* of limited size, located in suitable areas. Cosmetic outcome, body site, healing properties and vascularity of the area need to be considered	C
5-Fluorouracil: commercially available in the U.K. as a 5% cream. Less effective than PDT but not significantly different from cryotherapy (protocol dependent). It is more practical than surgery for large lesions, especially at potentially poor healing sites	B
Imiquimod: available as a topical 5% cream but is currently unlicensed for SCC *in situ*. It is generally well tolerated, but it does cause significant erythema and crusting, so appropriate counselling needs to be given prior to treatment	B
Laser: limited evidence, considered for potentially more challenging treatment sites including the digits and genitalia	D
Mohs micrographic surgery: may be indicated for digital SCC *in situ* (around the nail in particular) and for some cases of genital (especially penile) SCC *in situ* for its tissue-sparing benefits	D
No treatment: in some patients with slowly progressive thin lesions, especially on the lower leg of the elderly, there is an argument for observation. In these cases regular use of an emollient (especially one containing urea) can reduce the scaling and make it less obvious	D (GPP)

Treatment	Strength of Recommendation
PDT: more effective and superior cosmesis than cryotherapy and 5-fluorouracil (protocol dependent). It may be of particular benefit for lesions that are large (>3 cm diameter), on the lower leg, or at otherwise difficult sites. Pain is a common side-effect	A
Radiotherapy: can be used to treat areas where surgical modalities are difficult. Disadvantages include cost, patient convenience and poor healing, particularly on the leg	D

GPP, good practice point; PDT, photodynamic therapy; SCC, squamous cell carcinoma

Definitions:

Levels of Evidence

Level of Evidence	Type of Evidence
1++	High-quality meta-analyses, systematic reviews of randomized controlled trials (RCTs), or RCTs with a very low risk of bias
1+	Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
1-	Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias*
2++	High-quality systematic reviews of case–control or cohort studies High-quality case-control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relationship is causal
2+	Well-conducted case-control or cohort studies with a low risk of confounding, bias or chance and a moderate probability that the relationship is causal
2-	Case-control or cohort studies with a high risk of confounding, bias or chance and a significant risk that the relationship is not causal*
3	Non-analytical studies (for example, case reports, case series)
4	Expert opinion, formal consensus

*Studies with a level of evidence '–' should not be used as a basis for making a recommendation.

Strength of Recommendation

Class	Evidence
A	• At least one meta-analysis, systematic review, or randomized controlled trial (RCT) rated as 1++, and directly applicable to the target population or • A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results or • Evidence drawn from a National Institute for Health and Care Excellence (NICE) technology appraisal
B	• A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results, or • Extrapolated evidence from studies rated as 1++ or 1+
C	• A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results, or • Extrapolated evidence from studies rated as 2++

Class	Evidence
D	• Evidence level 3 or 4, or • Extrapolated evidence from studies rated as 2+ or • Formal consensus
D (GPP)	• A good practice point is a recommendation for best practice based on the experience of the guideline development group

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Squamous cell carcinoma *in situ* (Bowen's disease)

Guideline Category

Management

Treatment

Clinical Specialty

Dermatology

Oncology

Intended Users

Advanced Practice Nurses

Nurses

Physician Assistants

Physicians

Guideline Objective(s)

- To provide up-to-date, evidence-based recommendations for the management of squamous cell carcinoma (SCC) *in situ* (Bowen's disease)
- To update and expand on the previous guidelines by (i) offering an appraisal of all relevant literature since January 2006, focusing on any key developments; (ii) addressing important, practical clinical questions relating to the primary guideline objective, i.e. accurate diagnosis and identification of cases and suitable treatment; (iii) providing guideline recommendations and, where appropriate, some health economic considerations; and (iv) discussing potential developments and future directions

Note: The guideline also reviews erythroplasia of Queyrat (EQ)/penile intraepithelial neoplasia (PIN) and bowenoid papulosis, which have similar histology and are often diagnosed by dermatologists; however, a detailed therapeutic review of these conditions is beyond the scope of this guideline. This guideline does not offer treatment recommendations for vaginal intraepithelial neoplasia or perianal SCC *in situ*.

Target Population

Patients with squamous cell carcinoma *in situ* (Bowen's disease)

Interventions and Practices Considered

1. Observation (no treatment)
2. 5-Fluorouracil (5-FU)
3. Imiquimod
4. Cryotherapy
5. Curettage with cautery/electrocautery
6. Excision (Mohs micrographic surgery)
7. Photodynamic therapy (PDT)
8. Radiotherapy
9. Laser

Major Outcomes Considered

- Ease of application/time required for procedure
- Wound healing
- Clearance rate
- Cosmetic result
- Costs of method
- Treatment response rate
- Recurrence rate
- Cure rate
- Morbidity
- Cost-effectiveness

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

The PubMed, MEDLINE and EMBASE databases were searched for meta-analyses, randomized controlled trials (RCTs) and non-RCTs, case series, case reports and open studies involving squamous cell carcinoma (SCC) *in situ* (Bowen's disease) to September 2013; search terms and strategies are detailed in the Supporting Information (see the "Availability of Companion Documents" field). Additional relevant references were also isolated from citations in the reviewed literature, as well as from a specific targeted search for penile intraepithelial neoplasia (PIN). Each author screened their set of identified titles, and those relevant for first-round inclusion were selected for further scrutiny.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

Level of Evidence	Type of Evidence
1++	High-quality meta-analyses, systematic reviews of randomized controlled trials (RCTs), or RCTs with a very low risk of bias
1+	Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
1-	Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias*
2++	High-quality systematic reviews of case–control or cohort studies High-quality case-control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relationship is causal
2+	Well-conducted case-control or cohort studies with a low risk of confounding, bias or chance and a moderate probability that the relationship is causal
2-	Case-control or cohort studies with a high risk of confounding, bias or chance and a significant risk that the relationship is not causal*
3	Non-analytical studies (for example, case reports, case series)
4	Expert opinion, formal consensus

*Studies with a level of evidence '–' should not be used as a basis for making a recommendation.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

The authors reviewed the abstracts for the shortlisted references, and the full papers of relevant material were obtained; disagreements in the final selections were resolved by discussion within the entire development group. The structure of the 2007 guideline was then discussed and re-evaluated, with headings and subheadings decided; different coauthors were allocated separate subsections. Each coauthor then performed a detailed appraisal of the selected literature, and all subsections were subsequently collated and edited to produce the final guideline.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

This set of guidelines has been developed using the British Association of Dermatologists' (BAD) recommended methodology (see the "Availability of Companion Documents" field), with reference to the Appraisal of Guidelines Research and Evaluation (AGREE II) instrument (www.agreetrust.org). It represents a planned regular update of the previous BAD guidelines for the management of

squamous cell carcinoma (SCC) *in situ* (Bowen's disease). Recommendations were developed for implementation in the U.K. National Health Service (NHS) using a process of considered judgement based on the evidence.

The guideline development group consisted of consultant dermatologists.

Recommendations take into account simplicity, cost and healing, as well as the type and validity of the published evidence base; for any treatment, there may be site-specific differences in the recommended option.

Rating Scheme for the Strength of the Recommendations

Strength of Recommendation

Class	Evidence
A	• At least one meta-analysis, systematic review, or randomized controlled trial (RCT) rated as 1++, and directly applicable to the target population or • A systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results or • Evidence drawn from a National Institute for Health and Care Excellence (NICE) technology appraisal
B	• A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results, or • Extrapolated evidence from studies rated as 1++ or 1+
C	• A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results, or • Extrapolated evidence from studies rated as 2++
D	• Evidence level 3 or 4, or • Extrapolated evidence from studies rated as 2+ or • Formal consensus
D (GPP)	• A good practice point is a recommendation for best practice based on the experience of the guideline development group

Cost Analysis

Therapy costs will vary depending on the location of services, staffing, volume of procedures and local protocols (e.g., frequency of biopsies prior to nonsurgical therapies).

A cost-minimization analysis based on costs incurred by the U.K. National Health Service (NHS) was published in 2003, comparing cryotherapy, curettage and cautery, excision, laser ablation, photodynamic therapy (PDT) and topical 5-fluorouracil (5-FU), in the treatment of squamous cell carcinoma (SCC) *in situ*. Assumptions included the expectation of diagnostic biopsy in all cases managed by nonsurgical options. Cryotherapy was costed at three visits to achieve clearance, while PDT was costed on two treatments. Curettage or excision biopsy were the cheapest treatments (£200), followed by 5-FU (£287), laser (£312) then cryotherapy (£392), with PDT being the most expensive (£457), although this was costed on more expensive light sources than in current use. This did not include the costs of complications or costs incurred by the patient or their relatives. A cost comparison based on published clearance/morbidity data (excluding the cost of a diagnostic biopsy) estimated the cost of successfully treating a single SCC *in situ* to be £119 for PDT, £145 for cryotherapy and £171 for 5-FU, which included additional clinic visits to manage complications.

In one small, retrospective study from Spain, of lesions located on the lower limbs, surgical excision of SCC *in situ* (n=54) and superficial basal

cell carcinoma (sBCC) (n=32) provided high cure rates, but was more expensive than nonsurgical modalities following calculation of the total medical cost, as well as direct and indirect costs. This study was costed on currently licensed methyl aminolaevulinate (MAL)-PDT, compared with earlier studies that costed aminolaevulinic acid (ALA)-PDT. After 2 years of follow-up, a complete response was observed in 89.5 % of the PDT group, 87.5% of the imiquimod group and 97.5% of the surgery group, but the average total cost for each treated tumour was €536 for surgery, €214 for PDT and €229 for imiquimod. Even allowing for reduced efficacy of the topical therapies, the cost per complete response was also lower with PDT and imiquimod than with surgery. In view of variations in drug pricing as well as service delivery, costings will vary between countries.

In the absence of new therapies, and with limited variation in treatment recommendations since the last guideline update, there should be no significant organizational or financial barriers to the treatment recommendations contained in this guideline. Cost pressures are most likely from increased prevalence of the condition and organizational changes impacting the availability of hospital-delivered therapies.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The guideline development group consisted of consultant dermatologists. The draft document was circulated to the British Association of Dermatologists' (BAD) membership, the British Dermatological Nursing Group (BDNG) and the Primary Care Dermatological Society (PCDS) for comments, and was peer reviewed by the Clinical Standards Unit of the BAD (made up of the Therapy and Guidelines Subcommittee) prior to publication.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate management of squamous cell carcinoma (SCC) *in situ* (Bowen's disease)

Potential Harms

- Cryotherapy may cause ulceration, especially on the lower leg
- Lower leg excision wounds may be associated with considerable morbidity
- Pain is a common side-effect of photodynamic therapy (PDT)
- In one open study of imiquimod, 38% of patients (six of 16) discontinued treatment early due to side-effects, but still had lesion clearance.
- Disadvantages of radiotherapy include patient inconvenience and poor healing, particularly on the leg. Complete clearance of lesions is widely reported following radiotherapy, but impaired healing on the lower leg was observed in a large retrospective study, leaving the authors to recommend that radiotherapy should not be used on lower-leg lesions.

Qualifying Statements

Qualifying Statements

- The authors intend that the recommendations and quality of evidence reflect the full evidence base at the time of writing and may be read without the need for reference to earlier versions, although detailed discussion of older studies is not repeated here. It should be recognized that this new version may give disproportionate weight to references to newer publications and therapies. Where there are direct comparisons between therapies, these are generally discussed in the section relating to those deemed to be most efficacious. Recommendations take into account simplicity, cost and healing, as well as the type and validity of the published evidence base; for any treatment, there may be site-specific differences in the recommended option.
- This document has been prepared on behalf of the British Association of Dermatologists (BAD) and is based on the best data available when the document was prepared. It is recognized that under certain conditions it may be necessary to deviate from the guidelines and that the results of future studies may require some of the recommendations herein to be changed. Failure to adhere to these guidelines should not necessarily be considered negligent, nor should adherence to these recommendations constitute a defense against a claim of negligence.
- All recommendations in this guideline are extrapolated from literature on squamous cell carcinoma *in situ* and knowledge of other neoplastic skin lesions, and are presented on the understanding that neither the authors nor the BAD can formally recommend an unlicensed treatment.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Audit Criteria/Indicators

Patient Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Morton CA, Birnie AJ, Eedy DJ. British Association of Dermatologists' guidelines for the management of squamous cell carcinoma in situ (Bowen's disease) 2014. Br J Dermatol. 2014 Feb;170(2):245-60. [174 references] PubMed

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

1999 (revised 2014 Feb)

Guideline Developer(s)

British Association of Dermatologists - Medical Specialty Society

Source(s) of Funding

British Association of Dermatologists

Guideline Committee

British Association of Dermatologists Therapy and Guidelines Subcommittee

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

C.A.M. has acted as an invited speaker for Galderma (specific), Astellas (nonspecific), Almirall (nonspecific) and LEO Pharma (nonspecific); has received sponsorship to attend conferences from LEO Pharma (nonspecific); and has participated in the advisory boards of Almirall, Astellas and LEO Pharma (nonspecific). D.J.E. has participated in the advisory board of, and received travel expenses from LEO Pharma (nonspecific). C.A.M., A.J.B. and D.J.E. are members of the guideline development group.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Cox NH, Eedy DJ, Morton CA, Therapy Guidelines and Audit Subcommittee, British Association of Dermatologists. Guidelines for management of Bowen's disease: 2006 update. Br J Dermatol. 2007 Jan;156(1):11-21. [70 references]

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the British Association of Dermatologists Web site .

Availability of Companion Documents

The following is available:

- Bell HK, Ormerod AD. Writing a British Association of Dermatologists clinical guideline: an update on the process and guidance for authors. Br J Dermatol 2009; 160:725-8. Electronic copies: Available in Portable Document Format (PDF) from the British Association of Dermatologists Web site .

Literature search strategies and search terms are available on the British Journal of Dermatology Web site .

In addition, recommended audit points are provided in Section 15 of the original guideline document .

Patient Resources

The following is available:

- Bowen's disease (squamous cell carcinoma *in situ*). Patient information leaflet. London (England): British Association of Dermatologists; 2013 Dec. 5 p. Available in Portable Document Format (PDF) from the British Association of Dermatologists Web site .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This NGC summary was completed by ECRI Institute on July 25, 2007. The information was verified by the guideline developer on August 19, 2007. This summary was updated by ECRI Institute on May 13, 2014. The updated information was verified by the guideline developer on June 10, 2014.

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